8655945739 DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH CARE FACILITY HOAY

PAGE 04/17 PRINTED; 10/13/2011 FORM APPROVED

NAME OF PROVIDER OR SUPPLIER  MANCHESTER HEALTH CARE CENTER  SIMPLESTER HEALTH CARE CENTER  SUMMARY STATEMENT OF DEPICIENCIES PREFIX TAG  SUMMARY STATEMENT OF DEPICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  FOOD  INITIAL COMMENTS  Complaint investigation #28747 and #28769, were completed on October 3, 2011, at Manchester Health Care Center. No deficiencies were cited related to complaint investigation #28769 under 42 CFR PART 482.13, Requirements for Long Term Care. Deficiencies were cited on C/O #28747.  F 157  A facility must immediately inform the resident, consult with the resident's physician, and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident's legal representative or an interested family member when there is an accident involving the resident's physician, and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident members in the resident's physician, and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident members when there is an accident involving the resident status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing on on the part due to adverse the potential on process starting on 09/202011.	(X3) DATE SURVEY COMPLETED			MULTIF JILDIN	1	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	T OF DEFICIENCIES OF CORRECTION	AND PLAN (
MANCHESTER HEALTH CARE CENTER  MANCHESTER HEALTH CARE CENTER  SUMMARY STATEMENT OF DEPICIENCIES  REGULATORY OR LOC IDENTIFYING INFORMATION)  FOOD  INITIAL COMMENTS  Complaint investigation #28747 and #28769, were completed on October 3, 2011, at Manchester Health Care Center. No deficiencies were cited related to complaint investigation #28.743, Requirements for Long Term Care. Deficiencies were cited on C/O #28747.  SS=D  A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physician, and electrication in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to ariverse	C	0.0000000000000000000000000000000000000	***************************************			445391		
PREFIX (EACH DEFICIENCY NUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 000 INITIAL COMMENTS  Complaint investigation #28747 and #28769, Were completed on October 3, 2011, at Manchester Health Care Center. No deficiencies Were cited related to complaint investigation #28769 under 42 CFR PART 482.13, Requirements for Long Term Care. Deficiencies Were cited on C/O #28747.  F 157  As 3.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)  A facility must immediately inform the resident, consult with the resident's physician, and if known, notify the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physician, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment existing form of treatment due to adverse	03/2011	10/0.	95 INTERSTATE DRIVE	39	d	E CENTER		
Complaint investigation #28747 and #28769, were completed on October 3, 2011, at Manchester Health Care Center. No deficiencies were cited related to complaint investigation #28769 under 42 CFR PART 482.13, Requirements for Long Term Care. Deficiencies were cited on C/O #28747.  F 157 SS=D  A facility must immediately inform the resident; consult with the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physician; and if status in either life threatening conditions or clinical complications); a need to discontinue an existing form of treatment due to ariverse	COMPLET DATE	ULD BE	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	FIX	PRE	Y MUST BE PRECEDED BY FULL	(EACH DEFICIENC	PREFIX
Complaint investigation #28747 and #28769, were completed on October 3, 2011, at Manchester Health Care Center. No deficiencies were cited related to complaint investigation #28769 under 42 CFR PART 482.13, Requirements for Long Term Care. Deficiencies were cited on C/O #28747.  F 157 SS=D  Kas.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)  A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status (i.e., a deterioration in freatment due to adverse existing form of treatment due to proverse	09/26/20	ncluded		000	F	TS	INITIAL COMMEN	F 000
A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to discontinue an existing form of treatment due to adverse	10/41	and was hysician were tained 011 so that dent upon ted 100% erformed by	resident was sent to the ER for evaluation and admitted on 09/19/2011. The family and Phys notified by DON on 09/19/2011. DON obtain medication from the pharmacy on 09/19/2011 medication would be available for this residen readmission to the facility. 09/19/2011 started licensed nursing staff in-service that was perfethe DON/ADON regarding pharmacy policy as			October 3, 2011, at Care Center. No deficiencies to complaint investigation FR PART 482.13, ong Term Care. Deficiencies #28747.	were completed on Manchester Health were cited related t #28769 under 42 C Requirements for L were cited on C/O #	
consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).  The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.  The facility must also promptly notify the resident week by DON/ADON, and then will be performed weekly for two months, then monthly for two months. Any adverse results will be reported to the QA committee Results of this monitoring will be reported to the QA committee for analysis findings. Changes will be made to the action plan based on analysis. The QA committee consist of Administrator, DON, ADON, Nurse Educator, Activities director, Medical Director, Medical records, Dictary director, Environmental		rvicing was a-serviced as involved as involved aninated on acted by this coughout the attributed to ensure and to be ant practice and nursing anolicy and anotification as licensed an process to licensed an ensure building for 2 formed a months. A athe QA all be made a athropy, Director	of lamily and physician notification. In service completed on 09/26/2011 with all nurses in-service to returning to facility. The two nurses in were immediately suspended and were termina 9/23/2011.  All residents have the potential to be affected practice. All residents in medications were audited through building on 09/19/2011 by the DON/ADON to availability. No other medications where found unavailable.  Measures put into place to ensure deficient procedure, medication administration, and notion of family and physician notification. All new list staff will be oriented as part of the orientation procedure, medication administration, and notion of family and physician notification. All new list staff will be oriented as part of the orientation procedure, medication administration in starting on 09/20/2011.  Pharmacy provided an additional in-service to I nursing staff on 09/21/2011.  The corrective actions will be monitored to expractice will not recur includes:  Medication availability audits for the entire built were performed starting daily on 09/19/2011 for weeks by DON/ADON, and then will be perform weekly for two months, then monthly for two many adverse results will be reported to the QA committee.  Results of this monitoring will be reported to the committee for analysis findings. Changes will to the action plan based on analysis. The QA committee consist of Administrator, DON, ADON urse Educator, Activities director. Medical Director and the content of the			ediately inform the resident, ident's physician; and if isident's legal representative nily member when there is an increased to the resident which results in otential for requiring physician ficant change in the resident's psychosocial status (i.e., a th, mental, or psychosocial hreatening conditions or s); a need to alter treatment meed to discontinue an timent due to adverse a commence a new form of ision to transfer or discharge a facility as specified in a promptly notify the resident sident's legal representative member when there is a commate assignment as 5(e)(2); or a change in Federal or State law or	483.10(b)(11) NOT (INJURY/DECLINE A facility must imme consult with the res known, notify the re or an interested fam accident involving the injury and has the printervention; a signify physical, mental, or deterioration in health status in either life the clinical complication significantly (i.e., an existing form of treatconsequences, or a decident from the \$483.12(a).  The facility must also and, if known, the report interested family received in \$483.15 are sident rights under regulations as specified in \$483.15 are sident rights under regulations as specified.	SS=D

Any ther safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days lays following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 srogram participation.

ORM CMS-2567(02-99) Previous Versions Obsolete	Event ID: 147R11	Facility ID: TN1604	If no diversity and the second
10/20/11 4:00 pm Message Le			Completion clate. mad.
0/27/11 11:40 Am. Perm. 55. completion date			

HEALTH CARE FACILITY

PAGE 05/17

RINTED:	10/13/2011
FORM A	APPROVED

DEPAR	TMENT OF HEALTH	I AND HUMAN SERVICES					0: 10/13/2011
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES					0.0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL		CONSTRUCTION	(X3) DATE COMPI	SURVEY
		445391	B, WING	3		100	C
NAME OF F	PROVIDER OR SUPPLIER		1:	STREE	T ADDRESS, CITY, STATE, ZIP COD		03/2011
MANCHE	ESTER HEALTH CAR	E CENTER		395	INTERSTATE DRIVE NCHESTER, TN 37355		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 157	Continued From pa	ge 1	F 15	57	1 7 Mary distribution ( & ) recombination		
15%	The facility must re-	cord and periodically update one number of the resident's or interested family member.					
	by: Based on medical review, facility invest the facility failed to for anti-seizure med physician anti-seizu available for the restamily the anti-seizu	record review, facility policy stigation review, and interview, notify pharmacy of the need dications; failed to notify the are medications were not sident; and failed to notify the are medications were (#3) of seven residents		The same of the sa			
	September 17, 201 Seizures, Diabetes Coronary Artery Dis Stents. Continued r revealed the resider Facility; had been he	mitted to the facility on  1, with diagnoses including Mellitus, Hypertension, ease with Placement of medical record review at lived in an Assisted Living aspitalized due to aspiration s transferred to the facility for	er er er				
	dated September 6, had a BIMS (Brief In 10 (15 being fully ale assistance with trans grooming; was conti	ew of the Minimum Data Set 2011, revealed the resident eventory of Mental Status) of ert and oriented); required sfers, dressing, bathing, and nent of bowel and bladder; the eating; used a walker or ity.			*	,	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

HEALTH CARE FACILITY

PAGE 05/17 PRINTED: 10/13/2011 FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICAR	E & MEDICAID SERVICES				CIVID NO.	0930-0391
TATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	Ā. BUII	DING	PLE CONSTRUCTION	(X3) DATE S COMPLE	
		445391	B. WIN	IG		10/0	3/2011
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 395 INTERSTATE DRIVE MANCHESTER, TN 37355				
(X4) ID PREFIX TAG	(EACH DEFICIENCE	TATEMENT OF DEFICIENCIES OY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 157	September 19, 20 the front lobby in a seizure. Continue revealed the resident the seizure and won the floor. Furtinevealed the resident which the recontinued medicaresident suffered.	view of nursing notes dated 111, revealed the resident was in the wheelchair whenhad a ded medical record review dent was non-responsive after as placed on the resident's side the mer medical record review dent suffered a second seizure sident required suctioning. The seizure as third seizure before being	F	157	e v		
60 (10 (10 (10 (10 (10 (10 (10 (10 (10 (1	Department record mal seizure due to hours. Patient ha	hospital, view of the Emergency d revealed patient had "grand" o not receiving Lamictal for 48 id history of seizures 3-4 years, zures if., does not receive				e e	
	orders dated Aug resident was orde	view of physician's admission ust 17, 2011, revealed the red Lacosamide (Lamictal) 100 very 12 hours for seizures.			×		
	Administration Re resident received 2011, at 7:51 p.m review of the MAF not administered	view of the Medication accord (MAR) revealed the the Lamictal on September 17, . Continued medical record revealed the medication was on September 18, 2011, at 8:00 , nor was it administered on 111, at 8:00 a.m.			•		
	2011, revealed the pharmacy reques	entation dated September 18, e nurse sent an email to the ting the medication, but failed to pharmacy by telephone to get					

HEALTH CARE FACILITY

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PRINTED: 10/13/2011

DEPAR CENTE	RTMENT OF HEALTI	HAND HUMAN SERVICES  E & MEDICAID SERVICES				FORM	0: 10/13/2011 MAPPROVED 0: 0938-0391
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		PLE CONSTRUCTION G	(X3) DATE S	SURVEY
		445391	B. WING			104	C
	PROVIDER OR SUPPLIER ESTER HEALTH CAR	E CENTER		3	REET ADDRESS, CITY, STATE, ZIP COD 95 INTERSTATE DRIVE MANCHESTER, TN 37355		03/2011
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION I CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 157	the medication call review of documen 2011, revealed the medication was "he from pharmacy." Of documentation data revealed the nurse requesting the medication the back-up pharmacy later in the back-up pharmacy. Call onmessage of order revill call back and all	ed into the pharmacy. Further tation dated September 18, evening nurse charted the eld due to waiting available continued review of ed September 19, 2011, sent an email to the pharmacy lication and then called the morning who stated they extrem the medication was in	F	157			
	pharmacy there was resident. Continued September 18, 201 the medication was notify the backup of the medication to the revealed on September 18 and the medication to the revealed on September 19, 201 was none to give an pharmacy and follow	v the protocol.	8	The same of the sa			
	September 20, 2011 "did not call backu 18, 2011, to obtain r	nterview with Nurse #1 dated revealed the employee p pharmacy on September nedication for resident his resident missed a dose of	ş.				

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HEALTH CARE FACILITY

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER; (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION COMPLETED A. BUILDING C B. WING 445391 10/03/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 395 INTERSTATE DRIVE MANCHESTER HEALTH CARE CENTER MANCHESTER, TN 37355 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5)(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX TAG TAG F 157 Continued From page 4 F 157 anti-seizure medication during this employee's shift. Family was not notified; physician was not notified; pharmacy was not notified by phone. This employee is suspended pending investigation at this time." Review of a facility interview with Nurse #2 on September 23, 2011, revealed "This employee did not attempt to obtain medication from pharmacy on September 18, 2011. Family was not notified nor was the physician." Continued review of facility investigation revealed both employees were terminated. Review of facility policy, Medication Administration, revealed "The Director of Nursing and resident's attending physician will be notified when three (3) consecutive doses of a medication are refused or withheld. With medications such as Cardiac, Anticonvulsants, and/or Diabetic drugs with one missed dose, the physician is to be notified. The reporting nurse will chart this notification in the nurses' notes in the resident's medical record." During interview on October 4, 2011, at 3:30 p.m., in the conference room, the Director of Nursing confirmed the nurse failed to follow correct procedures and falled to notify the pharmacy correctly the medications were not available; filed to notify the physician the medication had not been administered for three doses; and failed to notify the family the resident had not received three doses of medication. C/O #28747 F 281 483.20(k)(3)(i) SERVICES PROVIDED MEET F 281

HEALTH CARE FACILITY

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAR SERVICES

PAGE 09/17 PRINTED: 10/13/2011 FORM APPROVED OMB NO. 0938-0391

		CE & MEDICAID SERVICES				OMB NO.	0938-0391
STATEMEN AND PLAN (	T OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION UILDING		(X3) DATE SURVEY COMPLETED	
		445391	B. WII	1G _	1	- T	C 3/2011
	PROVIDER OR SUPPLIEF ESTER HEALTH CA			3	REET ADDRESS, CITY, STATE, ZIP CODE 195 INTERSTATE DRIVE MANCHESTER, TN 37355		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	IX.	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	COMPLETION DATE
F-281 SS=D	This REQUIREMS by: Based on medica review, facility lailed to in providing care to anti-seizure medica residents reviewed  The findings included Resident #3 was a September 17, 20 Seizures, Diabete: Coronary Artery D Stents. Continued revealed the reside Facility; had been pneumonia; and we rehabilitation.  Medical record revelated September 6 had a BIMS (Brief 10 (15 being fully a assistance with tra grooming; was con-	standards of quality sional standards of quality.  ENT is not met as evidenced at record review, facility policy estigation review, and interview, or meet professional standards or a resident by failing to obtain cations and failing to administer cations to one (#3) of seven d.  ded:  admitted to the facility on 11, with diagnoses including is Mellitus, Hypertension, is ease with Placement of a medical record review ent lived in an Assisted Living hospitalized due to aspiration ras transferred to the facility for liew of the Minimum Data Set 5, 2011, revealed the resident inventory of Mental Status) of alert and oriented); required insfers, dressing, bathing, and attinent of bowel and bladder; with eating: used a walker or	F		F281 Corrective action for resident affected resident was sent to the ER for evaluation admitted on 09/19/2011. The family and it notified by DON on 09/19/2011. DON of medication from the pharmacy on 09/19/2011 medication would be available for this respective to the ER for evaluation admitted for this respective to the facility. 09/19/2011 stable licensed nursing staff in-service that was the DON/ADON regarding pharmacy polyprocedure, medication administration, and of family and physician notification. In sompleted on 09/26/2011 with all nurses prior to returning to facility. The two nurse were immediately suspended and were ter 9/23/2011.  All residents have the potential to be after practice. All residents have the potential to be after practice. All residents medications were audited thoulding on 09/19/2011 by the DON/ADO availability. No other medications where unavailable.  Measures put into place to ensure deficit does not occur again are: 100% of licer staff were in-serviced regarding pharmacy procedure, medication administration, and of family and physician notification. All restaff will be oriented as part of the oriental starting on 09/20/2011.  Pharmacy provided an additional in-service nursing staff on 09/21/2011.  The corrective actions will be monitored practice will not recur includes:  Medication availability audits for the entire were performed starting daily on 09/19/20 weeks by DON/ADON, and then will be performed starting daily on 09/19/20 weeks by DON/ADON, and then will be performed starting daily on 09/19/20 to two months, then monthly for the Any adverse results will be reported to the committee for analysis findings. Changes to the action plan based on analysis. The Committee for analysis findings changes to the action plan based on analysis. The Committee consist of Administrator, DON, Nurse Educator, Activities director, Medic Medical records, Dietary director, Environ	and was Physician were btained 2011 so that sident upon arted 100% performed by icy and d notification ervicing was in-serviced ses involved rminated on fected by this proughout the DN to ensure found to be lient practice nsed nursing policy and foundification new licensed tion process the to licensed d to ensure the building 11 for 2 performed two months. QA to the QA will be made QA ADON, al Director, mental	09/26/2011   0   4   11

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HEALTH CARE FACILITY

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		I AND HUMAN SERVICES  & MEDICAID SERVICES			FC	NO. 0938-0391			
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION	(X3) DA	TE SURVEY			
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	PROVIDER OR SUPPLIER ESTER HEALTH CARI	E CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 395 INTERSTATE DRIVE MANCHESTER, TN 37355						
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F'281	Medical record revi September 19, 201	ge 6 ew of nursing notes dated 1, revealed the resident was in e wheelchair whenhad a	F 281	10 10					
	revealed the resider the seizure and was on the floor. Further evealed the resider after which the resider after which the resider after which the resider after which the resider that the resider after which the resider after which the resider that the resider	medical record review nt was non-responsive after s placed on the resident's side er medical record review nt suffered a second seizure dent required suctioning, record review revealed the third saizure before being			\$ 180 180				
¥	Department record mal seizure due to r hours. Patient had	ew of the Emergency revealed patient had "grand not receiving Lamictal for 48 history of seizures 3-4 years, res if., does not receive			а ж п				
	resident was ordere	ew of physician's admission t 17, 2011, revealed the d Lacosamide (Lamictal) 100 ry 12 hours for seizures.			8				
	resident received the 2011, at 7:51 p.m. (review of the MAR in not administered on	ord (MAR) revealed the a Lamictal on September 17, Continued medical record evealed the medication was September 18, 2011, at 8:00 or was it administered on							
	2011, revealed the n pharmacy requesting	tation dated September 18, surse sent an email to the g the medication, but failed to armacy by telephone to get							

HEALTH CARE FACILITY

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DEPAR'	TMENT OF HEALTH	AND HUMAN SERVICES					FORM	APPROVED
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES					OMB NO	. 0938-0391
STATEMENT AND PLAN C	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUIL		E CONSTRUCTION		(X3) DATE S COMPLI	ETED
4		445391	B. WIN	G			10/03/20	
	ROVIDER OR SUPPLIER ESTER HEALTH CAR	E CENTER		395	ET ADDRESS, CITY, STATE INTERSTATE DRIVE NCHESTER, TN 3735		**	
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F 281	review of document 2011, revealed the medication was "he from pharmacy." Of documentation data revealed the nurse requesting the medical pharmacy later in the would call the nurse the back-up pharmacy later the	ed into the pharmacy. Further tation dated September 18, evening nurse charted the eld due to waiting available Continued review of ed September 19, 2011, sent an email to the pharmacy dication and then called the morning who stated they e when the medication was in acy.	F2	81				
	pharmacy. Call on- message of order r will call back and a obtained from back delivery."  Review of the facilit September 17, 201 pharmacy there wa resident. Continue September 18, 201 the medication was notify the backup pi the medication to fr revealed on Septem nurse failed to give was none to give ar pharmacy and follor Review of a facility	lectronic MAR) and send to Call pharmacy and leave needed. On Call pharmacist rrange for medication to be cup pharmacy and arrange by investigation revealed on 1, the nurse failed to notify s no more Lamictal for the d review revealed the nurse on 1, notified pharmacy by email a not available but failed to harmacy by telephone to get the pharmacy. Further review niber 18, 2011, the evening the medication because there and also failed to notify we the protocol.						
	September 20, 201 "did not call backı	1, revealed the employee up pharmacy on September medication for resident			1993 21			

on...assigned hall. This resident missed a dose of

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HEALTH CARE FACILITY

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DEPARTMENT OF HEALTH AND HUMAN SERVICES	
CENTERS FOR MEDICARE & MEDICAID SERVICES	

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				. 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI	LTIPLE CONSTRUCTION DING	(X3) DATE S COMPL	BURVEY ETED
		445391	B. WING	)	10/0	C 03/2011
	PROVIDER OR SUPPLIER ESTER HEALTH CAR	E CENTER	.s	STREET ADDRESS, CITY, STATE, ZIP COI 395 INTERSTATE DRIVE MANCHESTER, TN 37355		
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F 281	shift. Family was r notified; pharmacy This employee is s investigation at this Review of a facility September 23, 201 did not attempt to c	ation during this employee's not notified; physician was not was not notified by phone. uspended pending time."  interview with Nurse #2 on 1, revealed "This employee obtain medication from ember 18, 2011. Family was	F 28	M		
	Review of facility pound in the continued review of facility pound in the continue of facility pound in the	of facility investigation revealed ere terminated.				
	2011, in the conference Nursing confirmed necessary anti-seiz pharmacy and faile	2:30 p.m., on October 4, ence room, the Director of the nurse failed to obtain ure medications from d to administer anti-seizure ered by the physician.				
F 333 SS=D	( ,,(,-, ,	DENTS FREE OF ERRORS	F 33	3		
	The facility must en	sure that residents are free of			)¥	The Arts Arts Arts Arts Arts Arts Arts Arts

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

HEALTH CARE FACILITY

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PRINTED: 10/13/2011 FORM APPROVED OMB NO. 0038-0301

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES					0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SI COMPLE	URVEY
		445391	B. WIN	1G _		1	C 2/2044
	PROVIDER OR SUPPLIER	CENTED			REET ADDRESS, CITY, STATE, ZIP CODE	10/0.	3/2011
1417(10) 11	ESTER NEALTH CAR	CENTER.		(C) (C) (C)	MANCHESTER, TN 37355	*	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	by: Based on medical review, facility invest the facility failed to medications and fair medication for one reviewed.  The findings include Resident #3 was ad September 17, 201 Seizures, Diabetes Coronary Artery Dis Stents. Continued revealed the resider Facility; had been he pneumonia; and warehabilitation.  Medical record revied dated September 6, had a BIMS (Brief In 10 (15 being fully aleassistance with transgrooming; was continued in wheelchair for mobility Medical record revied September 19, 2011 the front lobby in the seizure. Continued in the seizure.	ication errors.  IT is not met as evidenced record review, facility policy digation review, and interview, obtain anti-seizure led to administer anti-seizure (#3) of seven residents  ad:  mitted to the facility on I, with diagnoses including Mellitus, Hypertension, ease with Placement of medical record review at lived in an Assisted Living ospitalized due to aspiration is transferred to the facility for exercise to the facility for exercise to the facility for exercise to the medical record review at lived in an Assisted Living ospitalized due to aspiration is transferred to the facility for exercise to the facility for exercise to the facility for exercise to the minimum Data Set 2011, revealed the resident ventory of Mental Status) of extrand oriented); required exercises, dressing, bathing, and ment of bowel and bladder; the eating: used a walker or	F3	3333	F333 Corrective action for resident affected in resident was sent to the ER for evaluation a admitted on 09/19/2011. The family and Ph notified by DON on 09/19/2011. DON oh medication from the pharmacy on 09/19/20 medication would be available for this residence and mission to the facility. 09/19/2011 star licensed nursing staff in-service that was puthe DON/ADON regarding pharmacy police procedure, medication administration, and of family and physician notification. In sercompleted on 09/26/2011 with all nurses in prior to returning to facility. The two nurses were immediately suspended and were term 9/23/2011.  All residents have the potential to be affer practice. All residents have the potential to be affer practice. All residents medications were audited throbuilding on 09/19/2011 by the DON/ADON availability. No other medications where for unavailable.  Measures put into place to ensure deficie does not occur again are: 100% of licens staff were in-serviced regarding pharmacy procedure, medication administration, and rof family and physician notification. All ne staff will be oriented as part of the orientatic starting on 09/20/2011.  Pharmacy provided an additional in-service nursing staff on 09/21/2011.  Pharmacy provided an additional in-service were performed starting daily on 09/19/201 weeks by DON/ADON, and then will be per weekly for two months, then monthly for two Any adverse results will be reported to the Committee  Results of this monitoring will be reported to committee for analysis findings. Changes we to the action plan based on analysis. The Qcommittee consist of Administrator, DON, Aurse Educator, Activities director, Environm services, Social services, Maintenance, Rehalmiscine Coordinate.	and was hysician were tained of the state of	09/26/2011

DEPARTMENT OF HEALTH AND HUMAN SERVICES

HEALTH CARE FACILITY

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CENTE	RS FOR MEDICARI	& MEDICAID SERVICES				OMB NO	. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445391		(X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		B. WI	1G		C 10/03/2011		
NAME OF PROVIDER OR SUPPLIER MANCHESTER HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 395 INTERSTATE DRIVE MANCHESTER, TN 37355			1 19/55/2011	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHO TAG CROSS-REFERENCED TO THE APPL DEFICIENCY)		DULD BE	COMPLETION DATE	
F 333	on the floor. Further revealed the reside after which the resident medical resident suffered a transferred to the hadical record revident seizure due to hours. Patient had	s placed on the resident's side er medical record review ent suffered a second seizure dent required suctioning. record review revealed the third seizure before being	F	333			
¥	resident was order	ew of physician's admission st 17, 2011, revealed the ed Lacosamide (Lamictal) 100 ery 12 hours for seizures.		.			
	Administration Rec resident received the 2011, at 7:51 p.m. review of the MAR not administered or	ew of the Medication ord (MAR) revealed the se Lamictal on September 17, Continued medical record revealed the medication was a September 18, 2011, at 8:00 nor was it administered on 1, at 8:00 a.m.			* * * * * * * * * * * * * * * * * * *		
į	2011, revealed the pharmacy requestir notify the backup pl the medication calle review of document 2011, revealed the	ntation dated September 18, nurse sent an email to the 19 the medication, but failed to narmacy by telephone to get 19 d into the pharmacy. Further 19 ation dated September 18, evening nurse charted the 19 d due to waiting available ontinued review of					

## HEALTH CARE FACILITY

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB NO. 0938-0391 (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445391		(X1) PRÖVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		B.'WING	10/03/2011			
	ROVIDER OR SUPPLIER	E CENTER	39	EET ADDRESS, CITY, STATE, ZIP CODE IS INTERSTATE DRIVE ANCHESTER, TN 37355		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (ÉACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		ULD BE   COMPLETION	
F 333	revealed the nurse requesting the med pharmacy later in the	ed September 19, 2011, sent an email to the pharmacy dication and then called he morning who stated they when the medication was in	F 333			
	order into E-Mar (e pharmacy. Call on- message of order i will call back and a	macy policy revealed "Enter lectronic MAR) and send to Call pharmacy and leave needed. On Call pharmacist rrange for medication to be cup pharmacy and arrange				
	september 17, 201 pharmacy there was resident. Continue September 18, 201 the medication was notify the backup p the medication to the revealed on September 18, 201 provides the medication to the medication to the medication to the revealed on September 19, 201 provides the medication to the medicat	ty investigation revealed on 1, the nurse failed to notify is no more Lamictal for the direview revealed the nurse on 1, notified pharmacy by emails not available but failed to harmacy by telephone to get ne pharmacy. Further review in the medication because there and also failed to notify with the protocol.				
. [	September 20, 201 "did not call backs 18, 2011, to obtain onassigned hall." anti-seizure medica shift. Family was n	interview with Nurse #1 dated 1, revealed the employee up pharmacy on September medication for resident This resident missed a dose of tion during this employee's ot notified; physician was not was not notified by phone. uspended pending time."				

HEALTH CARE FACILITY

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CENT	ERS FOR MEDICARE	AND HUMAN SERVICES  & MEDICAID SERVICES			PRINTED: 10/13/2011 FORM APPROVED OMB NO. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/OLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL A. BUILD	TIPLE CONSTRUCTION NNG	(X3) DATE SURVEY COMPLETED	
		B. WING		10/03/2011		
NAME OF	PROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP COI		
	HESTER HEALTH CAR			395 INTERSTATE DRIVE MANCHESTER, TN 37355		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE COMPLETION	
F 33	Continued From pa	ge 12	F 33	3		
5.	did not attempt to o	Interview with Nurse #2 on 1, revealed "This employee btain medication from ember 18, 2011. Family was the physician."				
	Continued review o both employees we	f facility investigation revealed re terminated.	a)			
	when three (3) cons are refused or with as Cardiac, Anticon drugs with one miss be notified. The res	olicy, Medication caled "The Director of Nursing ding physician will be notified elective doses of a medication caled. With medications such vulsants, and/or Diabetic sed dose, the physician is to corting nurse will chart this urses' notes in the resident's				
2	Nursing confirmed t anti-seizure medical policy and also filed	October 4, 2011, at 2:30 noe room, the Director of the nurses failed to obtain tions from the pharmacy per to administer anti-seizure vere ordered by the physician.	70 ·			
	C/O #28747					
			ε,			